The State Budget Office and Blue Cross jointly develop a Third Party purchaser position on the MAXICAP. The hospitals through HARI develop their position. This is done by first weighting the budgetary components of a hospital's budget, e.g. salaries and wages represent approximately 55-65 percent of a hospital's gross operating expenses. Then using the historical experience of hospitals, economic trends, both national and local, as may be reflected in such indices as the consumer price index and the wholesale price index; the labor contract experience, both nationally and locally; economists' predictions for the upcoming fiscal year; rates of interest; anticipated or known Federal, State, and local regulations which may impact expenses; known medical and capital programmatic development that has been approved by the planning process; and any other relevant factors that may have a bearing on hospital operating costs, the parties mutually develop and negotiate inflation or growth factors which are then applied to the budgetary components. The result is a tabulation of percentage increases for salaries and wages, physician salaries and fees, supplies and expenses, depreciation and interest, the carryover effect of new and expanded programs implemented in the prior year, new programs, volume and intensity, etc. The sum of these factors plus a reserve factor for unforeseen expenses and volume/intensity fluctuations equals a MAXICAP percentage increase for the next fiscal year. The resulting MAXICAP is a negotiated result of the parties' initial positions. This final percentage is then multiplied by the current fiscal year's expense base (negotiated expense budgets plus allowances for volume, patient mix, and major contingencies of a recurring nature) to arrive at a "pot of dollars" to be distributed among the sixteen voluntary hospitals based on the results of individual hospital budget negotiations.

It is intended that the MAXICAP will not be exceeded during the fiscal year. However, there will always be unforeseen expenses such as those expenses due to unexpected volume fluctuations or extraordinary, unforeseen expenses such as the significant increase in malpractice insurance premiums. The reserve factor in the MAXICAP was designed to absorb such expenses. There may, however, be occasions when the reserve is insufficient for that purpose. In these instances the MAXICAP may be exceeded by mutual agreement of the program participants. This will be addressed later.

2. Program Planning

Another important aspect of the Rhode Island Program, perhaps the first of its kind, is the integration of health care planning with the reimbursement function. Control of hospital costs and the rational distribution of resources to meet the demands of the health care community cannot fully take place unless planning is linked to the reimbursement system. Recent passage of PL 93-641 has acknowledged this fact. In Rhode Island, both the review and approval of capital projects and the review of new and/or expanded medical programs are linked to the Prospective Reimbursement Program.

Program Review and Approval Process

Rhode Island has for some time had a review mechanism for certificate of need. All major capital projects that meet the dollar threshold are submitted to the Rhode Island Department of Health for review. Only those projects receiving the Department's approval are given consideration during budget negotiations with the costs of interest, depreciation, and general operating expenses subject to the same scrutiny and negotiations as any other budget item.

In addition, there is a unique mechanism for review of medically oriented programs. This review process was part of the original Prospective Reimbursement Program in 1971 and was again incorporated in the revised program. Each spring, hospitals are required, under the terms of the Blue Cross Member Hospital Contract, to submit those new and/or expanded medically oriented programs that meet a predetermined dollar threshold to the voluntary Health Planning Council (HPC) for review. HPC then reviews and evaluates those program requests based on a predetermined set of criteria relating to proof of community need, consistency with the hospital's goals and objectives, relationship to other community programs, consideration of appropriate alternatives, the scope of the program, programmatic costs, and program effectiveness. Based on its findings, HPC then ranks the programs and assigns priorities: Priority I - those programs that should be implemented within the fiscal year; Priority II - programs with merit that may require more planning; and, Priority III - programs which should not be implemented. HPC further prioritizes the Priority I programs. Those rankings are then transmitted to the Third Parties for consideration in budget negotiations.

Only those programs which receive a Priority I ranking are considered by the Third Parties with the program budgets and dates of implementation subject to negotiations. It must be noted that all Priority I programs may not be automatically accepted for implementation in a given fiscal year. Like any other budget item, new programs are subject to the availability of resources within the MAXICAP.

A hospital may also budget any other programs which are not specifically subject to review by HPC or the Department of Health. These programs are also subject to budget negotiations and are carefully considered where a

hospital can demonstrate need and cost effectiveness. However, it must be noted that priority must be given to those programs approved by the planning process due to the limit of resources within the MAXICAP.

3. Hospital Budgets/Budget Negotiations

A cornerstone of the Rhode Island Program is the negotiation of each hospital's budget. As previously noted, the MAXICAP provides the flexibility to settle an individual hospital's budget above or below the MAXICAP percentage. The ultimate objective is to negotiate a budget that meets the hospital's operational needs and which is justifiable from the Third Parties' point of view, while still maintaining the integrity of the MAXICAP. Several provisions are necessary for this process to be successful.

a. The Budget Package - (Attachment 1). Each hospital is required to submit on or about June 15 (after MAXICAP negotiations are completed) a detailed budget request for the next fiscal year. The budget submission is a twenty-two page document mutually developed and agreed to by all parties and includes detailed schedules of: a summary of revenues and expenses, salary expense, fringe benefits, physician fees and salaries, supplies and expenses, interest expense, depreciation on plant and equipment, total depreciable assets, new and expanded programs, increases due to volume, new and expanded programs implemented in the current fiscal year, personnel/man-hours, summary of selected statistics, and narrative information explaining budgeting techniques and any unusual expenses or items for consideration. Each schedule must provide budget data for the present fiscal year, the prior year, and the budget year by major service. In addition, since all hospitals subscribe to the Commission on

Professional and Hospital Activities, they are requested to furnish PAS length of stay summary data for the last twelve months. Hospitals may also submit any other additional information in support of their budget requests.

b. IHDS Data - (Attachments 2 and 3). Hospitals must also submit IHDS (Interagency Hospital Data Service System, a locally designed statistical reporting system) data on a monthly basis which provides statistical and financial information by individual hospital. Among the data provided is inpatient utilization by major service, including bed counts, admissions, incurred patient days, and occupancy rates; patient revenue, actual as compared to budget; paid man-hours by major departments; gross operating expenses including salaries and wages, supplies and expenses, depreciation and interest, etc.; and selected ancillary statistics by major department. As can be readily seen, the information provided via IHDS is very similar to that provided in the budget package. The reason for this will be evident in the discussion of budget analysis.

c. Budget Review and Analysis - (Attachment 5). With the necessary data available to the parties, the basis exists for rational review and analysis of a hospital's budget.

The Third Parties' review and analysis of a hospital's budget are designed to rationally assess the hospital's needs in the budget year. The process begins with a categorization of the budget package and other relevant data:

- Identification of significant budget changes.
- Comparisons between miscellaneous revenues and expenses to actual data.
- Cost per unit of service analysis is completed, utilizing selected statistics on the basis of impact on hospital cost.

- Total operating expenses are reviewed by comparing projected actual and budgets of a prior period to current fiscal year budget.
- A quantitative analysis by bed size, unit size, and by type of hospital (i.e. teaching hospitals) is performed.
- Additionally, each major unit of service is analyzed for volume, man-hours, salaries and wages, fringes, supplies and expenses, depreciation and interest, etc.

After the above statistical information and comparisons are arrayed, each hospital's budget is analyzed in relation to national, regional and local norms reflecting: costs per unit of service, cost per type of hospital, costs per bed size, salary and wage analysis, nursing service costs per patient day, etc. At the same time, an individual hospital's productivity and performance from one year to the next is analyzed and evaluated. Additional analytical information is also obtained from such sources as Hospital Administrative Services data, the American Hospital Association's annual report, a Comparative Cost Report as compiled by Hospital Association of Rhode Island, and various positions identified during MAXICAP negotiations. All of the above are utilized to assess the reasonableness of a hospital's budget request, both on a line-by-line basis and in its entirety forming the basis for the Third Parties' position on a given hospital's budget.

However, when all is said and done with the budget package, IHDS data, and the review and analysis of each hospital's budget submission, the end result -- a mutually agreed upon fiscal year budget — is reached through budget negotiations. Rather than rely on any artificially imposed budget for a hospital, either via governmental fiat or other arbitrary limitation, the parties have chosen to negotiate hospital budgets. The participants in those negotiations are the hospital,

Blue Cross and the State collectively, and HARI, both to observe and to provide technical assistance to the hospital.

Initial negotiating positions center around the hospital budget submission -- the hospital defending its initial request and the Third Parties presenting an initial position based on their review and analysis of the budget. From that point, budget negotiations are aimed at agreement on a total "bottomline" budget settlement (both dollars and statistics), although during the course of negotiations, each side may choose to argue specific positions on various issues, such as: salaries and wages, inflation, new programs, etc. However, within that "bottomline" settlement, the parties do identify specific dollar amounts, dates of implementation, and statistics for HPC Priority I programs and capital projects approved by the Department of Health.

It should be noted that negotiations are not limited to dollar amounts alone. As mentioned, the parties also negotiate the statistics associated with the budget. The importance of this aspect of the program will become evident in a later discussion on rate setting and volume.

The intent of the Rhode Island program is to maintain the management prerogatives of the institution to allocate its resources in the best manner possible to achieve the institution's goals. Therefore, the parties, while reviewing on a line-by-line basis, do not negotiate line-by-line settlement but have opted for the bottomline approach. This provides the hospital with the flexibility to manage its budget as it sees fit and its only obligations are to live within that negotiated budget and any specific agreements made on new programs. The entire goal is to leave the management and operation of Rhode Island hospitals to the institutions themselves.

4. Rate Determination

The establishment of rates for Rhode Island hospitals is more indirect than the approach used by a rate setting commission, for example. Primary emphasis is the negotiation of hospital expense budgets within the overall limit of a MAXICAP. Thus, rate determination is a by-product of this process. Hospital rates are established from the results of budget negotiations, budget cost finding, and the hospital's establishment of its charge structure. Since budget negotiations have already been addressed, the other two components will be briefly discussed and then all three related to the establishment of a hospital rate.

a. Hospital Charges. Hospitals are free to change their charges once during the fiscal year. Each hospital must determine a list of board approved hospital charges and dates of implementation at the beginning of the fiscal year. These are then transmitted to the Third Parties. Each hospital agrees to "guarantee" that charge list for the fiscal year. It may not be changed unless a hospital is granted a major contingency. The hospital is free to establish whatever charges it feels are necessary for the institution. Given the proposed charge list and the statistics negotiated with the expense budget, the hospital then establishes its revenue budget for the fiscal year.

b. Cost finding. Subsequent to negotiation of each hospital's budget, each hospital is required to process its budget through an acceptable cost finding process. A single cost finding is run and adjusted for each major purchaser

of care consistent with that purchaser's principles of reimbursement. For example, the cost finding for Blue Cross purposes assumes a straight-line method for depreciation; while under certain circumstances, Medicaid following the Medicare principles of reimbursement recognizes accelerated depreciation. Based on the results of the cost finding process and in conjunction with the hospital's charge structure and revenue budget, ratios of allowable costs to hospital charges (RCCs) are established for each major purchaser of care based on the lower of costs or charges principle. Each purchaser of care has two RCCs -- one for inpatient and one for outpatient. These RCCs are guaranteed prospectively by the participating State programs and Blue Cross.

In short, the Rhode Island Prospective Reimbursement program is one which indirectly establishes and regulates hospital rates, with the major emphasis being control of the major element affecting those rates -- hospital operating expenses. Up to this point, the emphasis of the discussion has been the concept of the MAXICAP and how expenses and ultimately, rates are established. The program does, however, contain two major provisions which provide exemptions to the MAXICAP; the negotiated expense budget; and, in some cases, the established prospective rates of reimbursement. These provisions are volume/patient mix and major contingencies.

5. Volume/Patient Mix

Volume has been a major point of controversy in the Rhode Island program. When the program was originally designed, the MAXICAP and the negotiated budget were all inclusive, including any unexpected volume that might occur. Hospitals quickly pointed out that they could not insure the risk of potential volume increases. Thus, volume corridors for inpatient routine and ancillary services

were established. There was some dispute about the intent and operation of these corridors in the first year of the program and these have subsequently been revised and a volume corridor has been added for outpatient services. However, it is now accepted that these volume corridors are designed to protect hospitals against the costs of unexpected volume and are not financial incentives. However, the volume corridor provisions do provide an incentive for hospitals to optimally use their facilities and shift where possible, costly inpatient care to the less expensive outpatient modalities.

The inpatient volume corridors are so designed that an institution will be reimbursed for increased or decreased volume in relation to fixed costs when activity is decreasing and variable costs when activity is increasing. There is also a volume corridor for outpatient services. However, hospitals are only reimbursed for increased outpatient volume with no adjustment for decreased volume. The key to the corridors is the hospital's budget revenue which is directly related to statistics.

The inpatient volume corridor is divided into two categories -- routine and ancillary. Days are the yardstick for measuring fluctuations in routine volume. A sliding scale adjustment to the budgeted per diem is made as actual inpatient days vary from budget days. The inpatient ancillary adjustment is based on a variation of actual inpatient ancillary revenue versus budget inpatient ancillary revenue. Since the revenue is the function of budgeted statistics and the hospital's charge structure, again the volume adjustment is related to a fluctuation in actual statistics versus budget statistics. As volume increases, a hospital receives only 35 percent of excess revenues generated to offset variable costs. When volume decreases, a 65 percent factor is applied to "uncollected" revenues and paid to the hospital to defray fixed costs.